ملهم



		Form Approved				
WHOSE	Records to	be Disclosed:				
NAME	First FLAVIA I	Middle D BENITEZ	Last			
SSN:	u	Birthday (mm	ı/dd/yy)			
บร	E ONLY: NUME	BERHOLDER (If oth	erthan above):			
NAME:	FLAVIA I	BENITEZ				
SSN:						

## AUTHORIZATION TO DISCLOSE INFORMATION TO

Cooley Manion Jones LLP 21 Custom House Street Boston, MA 02110

These persons are hereinafter referred to collectively as "THE AUTHORIZED RECIPIENT."

I further authorize said physicians, hospitals, clinics, pharmacies, psychiatrists, psychologists, therapists, or other providers of medical services or products to release to THE AUTHORIZED RECIPIENT all written, previously-created documents related to my physical or mental condition or the treatment given or services and products provided to me. This authorization specifically includes all paper documents, all medical "films" (MRI, X-ray, CT, sonogram, etc.) and associated reports, as well as all documents received by one provider of medical services or products from another provider of medical services or products, so-called "re-release" or "re-disclosure."

INDIVIDUAL authorizing disclosure:		IF not signed by subject of disclosure, speoify basis for authority to sign		
SIGN			1	ersonal representative (explain)
Flore Bout	(Parent/guardiar signatures regui	(Parent/guardian sign here if two signatures required by State law):		
03 / 23 / 06 / 9 / 23 / 06	Street Address PO BOX 243		· .	
Phone Number (with area code)  508)-345-5380  City  JAMAICA PI		LAIN	State MA	ZIP 02130-0021
SIGN	form or am satisfic	IF needed, second witne SIGN ▶	ss sign here (e.g., if signed	with "X" above):
Phone Number (or Address)	Phone Number (or Address)			
This general and special authorization to dis and other information under: P.L.104-191 (* Code section 7332; 38 CFR 1.475; 20 U.S.	'HIPAA''): 45 CFR p	arts 160 and 164; 42 U.S.	Code section 290dd-2; 42 C	,FR pari 2, 30 Q.S.